

		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0000091</u></p> <p>Facility Name: <u>Hancock County Nursing Home</u></p> <p>Address: <u>P.O. Box 160, 403 South Adams Street</u> <u>Carthage</u> <u>62321</u> Number City Zip Code</p> <p>County: <u>Hancock</u></p> <p>Telephone Number: <u>(217) 357-3131</u> Fax # <u>(217) 357-6076</u></p> <p>IDPA ID Number: <u>6004022</u></p> <p>Date of Initial License for Current Owners: <u>5/23/1905</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Jan Fleming</u> Telephone Number: <u>(217) 357-3131 ext. 2209</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/04</u> to <u>06/30/05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%;"> <tr> <td style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name <u>BKD, LLP</u> & Address) <u>501 N. Broadway, Suite 600 St. Louis, MO 63102-2102</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(314) 231-5544</u> Fax # () _____</td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name <u>BKD, LLP</u> & Address) <u>501 N. Broadway, Suite 600 St. Louis, MO 63102-2102</u>		(Telephone) <u>(314) 231-5544</u> Fax # () _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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STATE OF ILLINOIS

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Facility Name & ID Number Hancock County Nursing Home# 0000091 Report Period Beginning: 07/01/04 Ending: 06/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>57</u>	Intermediate (ICF)	<u>57</u>	<u>20,805</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>57</u>	TOTALS	<u>57</u>	<u>20,805</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>9,227</u>	<u>8,811</u>		<u>18,038</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,227</u>	<u>8,811</u>		<u>18,038</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 86.70%

D. How many bed-hold days during this year were paid by the Department?

143 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)Day Care

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 1970

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided N/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: N/A Fiscal Year: 6/30/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

Hancock County Nursing Home

0000091

Report Period Beginning:

07/01/04

Ending:

06/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary		415	215	630		630		630			1
2	Food Purchase		235,200		235,200		235,200		235,200			2
3	Housekeeping	53,638	469		54,107		54,107		54,107			3
4	Laundry	4,966		36,337	41,303		41,303		41,303			4
5	Heat and Other Utilities			77,776	77,776		77,776	(32,020)	45,756			5
6	Maintenance	42,380	623	7,566	50,569		50,569	(20,819)	29,750			6
7	Other (specify):*	2,648			2,648		2,648		2,648			7
8	TOTAL General Services	103,632	236,707	121,894	462,233		462,233	(52,839)	409,394			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	821,810	52,241	7,259	881,310		881,310		881,310			10
10a	Therapy			4,650	4,650		4,650		4,650			10a
11	Activities	37,358	4,219	143	41,720		41,720		41,720			11
12	Social Services	13,066		1,100	14,166		14,166		14,166			12
13	CNA Training											13
14	Program Transportation			1,246	1,246		1,246		1,246			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	872,234	56,460	19,198	947,892		947,892		947,892			16
	C. General Administration											
17	Administrative	11,500	534	730	12,764		12,764		12,764			17
18	Directors Fees											18
19	Professional Services			242	242		242		242			19
20	Dues, Fees, Subscriptions & Promotions			19,034	19,034		19,034	(3,913)	15,121			20
21	Clerical & General Office Expenses	29,733	877	8,103	38,713		38,713		38,713			21
22	Employee Benefits & Payroll Taxes			373,335	373,335		373,335		373,335			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,360	2,360		2,360		2,360			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			25,600	25,600		25,600	(8,687)	16,913			26
27	Other (specify):*											27
28	TOTAL General Administration	41,233	1,411	429,404	472,048		472,048	(12,600)	459,448			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,017,099	294,578	570,496	1,882,173		1,882,173	(65,439)	1,816,734			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number

Hancock County Nursing Home

#0000091

Report Period Beginning:

07/01/04

Ending:

06/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			94,511	94,511		94,511	(32,860)	61,651			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15	15		15		15			35
36	Other (specify):*											36
37	TOTAL Ownership			94,526	94,526		94,526	(32,860)	61,666			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	8,501	662	1,738	10,901		10,901		10,901			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,209	31,209		31,209		31,209			42
43	Other (specify):* Nauvoo Housing		22	10,816	10,838		10,838	(10,838)				43
44	TOTAL Special Cost Centers	8,501	684	43,763	52,948		52,948	(10,838)	42,110			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,025,600	295,262	708,785	2,029,647		2,029,647	(109,137)	1,920,510			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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Facility Name & ID Number **Hancock County Nursing Home**

0000091

Report Period Beginning: 07/01/04

Ending: 06/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(61,526)	5,6,26		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(32,860)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,913)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>Nauvoo Housing</u>	(10,838)	43		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (109,137)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (109,137)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Hancock County Nursing Home

ID# 0000091

Report Period Beginning: 07/01/04

Ending: 06/30/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Nauvoo Housing	\$ (10,838)	43	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(10,838)		49

Summary A

06/30/05

[illegible]

Summary B

06/30/05

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 07/01/04 Ending: 06/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	N/A						\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Hancock County Nursing Home**# **0000091** Report Period Beginning: **07/01/04** Ending: **06/30/05****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2004 report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2000	None	8	
	2001	None	9	
	2002	None	10	
	2003	None	11	
	2004	None	12	
				FOR OHF USE ONLY
				13 FROM R. E. TAX STATEMENT FOR 2004 \$ 13
				14 PLUS APPEAL COST FROM LINE 5 \$ 14
				15 LESS REFUND FROM LINE 6 \$ 15
				16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hancock County Nursing Home COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0000091

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

A.

Square Feet:

31,115

B. General Construction Type:

Exterior

Block

Frame

Number of Stories

1

C.

Does the Operating Entity?

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

N/A

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1989	\$ 23,718	1
2					2
3	TOTALS			\$ 23,718	3

Facility Name & ID Number Hancock County Nursing Home# 0000091

Report Period Beginning:

07/01/04

Ending:

06/30/05**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation	
4	52		1971	1971	\$ 848,801	\$ 5,851	10 to 40	\$ 5,851		\$ 816,530	4
5	5		1992	1992	1,243,226	35,593	5 to 40	35,593		528,555	5
6											6
7											7
8											8
9	Improvement Type**										
10	<u>Building Improvements:</u>										
11	Improvements 1970		1970		211		Various			211	10
12	Improvements 1972		1972		69		Various			69	11
13	Improvements 1983		1983		16,349	582	Various	582		13,138	12
14	Improvements 1984		1984		1,132		Various			1,132	13
15	Improvements 1985		1985		50,000	2,493	Various	2,493		48,750	14
16	Improvements 1987		1987		9,387	11	Various	11		9,370	15
17	Improvements 1988		1988		3,302		Various			3,302	16
18	Improvements 1989		1989		5,799		Various			5,799	17
19	Improvements 1990		1990		13,920	455	Various	455		13,920	18
20	Improvements 1992		1992		1,589	20	Various	20		901	19
21	Improvements 1993		1993		301,014	6,755	Various	6,755		125,094	20
22	Improvements 1994		1994		1,366		Various			1,366	21
23	Improvements 1995		1995		6,371	411	Various	411		4,684	22
24	Improvements 1996		1996		3,277		Various			3,277	23
25	Improvements 1997		1997		25,608	2,010	Various	2,010		19,831	24
26	Improvements 1998		1998		37,834	3,773	Various	3,773		28,360	25
27	Improvements 1999		1999		34,448	1,610	Various	1,610		27,976	26
28	Improvements 2000		2000		24,579	1,910	Various	1,910		15,691	27
29	Less Non Care Assets:										28
30	Grey House Education Building				(61,015)	(3,153)	Various	(3,153)		(56,820)	29
31	Nauvoo Housing - Carrie Manor				(290,683)	(6,687)	Various	(6,687)		(114,629)	30
32	Beauty Shop				(922)	(34)	Various	(34)		(563)	31
33											32
34											33
35	Less 41.17% allocation to rental space				(936,890)	(21,243)		(21,243)		(615,880)	34
36											35

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Burner for boiler	2003	43,350	2,162	15	2,162	\$	\$ 5,410	37
38	Doors (27) Plain Sliced	2004	6,075	404	15	404		606	38
39	Generator & Install	2004	23,369	1,554	15	1,554		2,330	39
40	Farnsworth Group Generator	2005	3,495	115		115		116	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Less 41.17% allocation to rental space		(31,408)	(1,744)		(1,744)		(3,484)	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,383,653	\$ 32,848		\$ 32,848	\$	\$ 885,042	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,383,653	\$ 32,848		\$ 32,848		\$ 885,042	1
2	Land Improvements:								2
3									3
4	Improvements 1973	1973	7,768		15			7,768	4
5	Improvements 1987	1987	2,395		10			2,395	5
6	Improvements 1989	1989	1,380		various			1,380	6
7	Improvements 1992	1992	7,382	466	various	466		6,681	7
8	Improvements 1993	1993	2,258		8			2,258	8
9	Improvements 1994	1994	343		10			343	9
10	Improvements 1997	1997	33,506	2,100	8	2,100		33,506	10
11	Improvements 1998	1998	13,693	618	various	618		9,039	11
12	Asphalt Sealer	2002	2,111		2			2,111	12
13	Driveway Sealer	2004	4,017	501	8	501		751	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,458,506	\$ 36,533		\$ 36,533		\$ 951,274	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 283,241	\$ 17,685	\$ 17,685	\$		\$ 208,532	71
72	Current Year Purchases	23,721	1,423	1,423			1,423	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 306,962	\$ 19,108	\$ 19,108	\$		\$ 209,955	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1991 Ford Van	1992	\$ 17,463	\$	\$	\$	4	\$ 17,463	76
77	Patient Transportation	Lift	1989	2,575				10	2,575	77
78	Patient Transportation	2001 Ford E/350 van	2001	47,952	6,010	6,010		4	47,952	78
79										79
80	TOTALS			\$ 67,990	\$ 6,010	\$ 6,010	\$		\$ 67,990	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,857,176	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 61,651	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 61,651	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,229,219	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Allocation to rental space	\$ 968,298	\$ 22,987	\$ 619,364	86
87	Grey House- Education Building	61,015	3,153	56,820	87
88	Nauvoo Housing - Carrie Manor	290,683	6,687	114,629	88
89	Beauty Shop	922	34	563	89
90					90
91	TOTALS	\$ 1,320,918	\$ 32,861	\$ 791,376	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Ending: 06/30/05

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER CNA _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER CNA _____
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	CNA Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ _____

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 576,364	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 8,000)	255,950		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,476		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	489,584		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,323,374	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	116,741		13
14	Buildings, at Historical Cost	2,063,967		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,015,369		16
17	Accumulated Depreciation (book methods)	(2,020,595)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,631,141		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,806,623	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,129,997	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 7,850	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	101,849		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,000		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	7,719		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 118,418	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Security Deposits</u>	1,900		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,900	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 120,318	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 5,009,679	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,129,997	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,051,015	1
2	Restatements (describe):		2
3	Restricted Assets released	(73)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,050,942	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(39,399)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Change in Unrealized Gain/Loss on Investmer	(1,864)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (41,263)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,009,679	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,195,050	1
2	Discounts and Allowances for all Levels	(453,085)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,741,965	3
B. Ancillary Revenue			
4	Day Care	75	4
5	Other Care for Outpatients		5
6	Therapy	5,892	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,967	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,617	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	45,600	16
17	Sale of Drugs	9	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	10,371	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 60,597	23
D. Non-Operating Revenue			
24	Contributions	11,789	24
25	Interest and Other Investment Income***	138,479	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 150,268	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Nauvoo Housing Rents</u>	31,170	28
28a	<u>Other Misc Income</u>	282	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 31,452	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,990,249	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	462,233	31
32	Health Care	947,892	32
33	General Administration	472,048	33
B. Capital Expense			
34	Ownership	94,527	34
C. Ancillary Expense			
35	Special Cost Centers	52,948	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,029,648	40
41	Income before Income Taxes (line 30 minus line 40)**	(39,399)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (39,399)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Page 20

Facility Name & ID Number Hancock County Nursing Home

0000091

Report Period Beginning: 07/01/04

Ending:

06/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,926	2,086	\$ 69,125	\$ 33.14	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,079	8,559	166,160	19.41	3
4	Licensed Practical Nurses	8,795	9,994	164,204	16.43	4
5	CNAs & Orderlies	41,801	45,551	418,016	9.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,278	2,490	23,420	9.41	9
10	Activity Assistants	1,338	1,462	13,938	9.53	10
11	Social Service Workers	795	795	13,066	16.44	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,337	3,337	42,380	12.70	17
18	Housekeepers	7,665	7,665	53,638	7.00	18
19	Laundry	808	808	4,966	6.15	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	521	521	11,191	21.48	22
23	Office Manager					23
24	Clerical	1,257	1,257	30,042	23.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	313	313	4,305	13.75	31
32	Other Health Care(specify)	130	130	2,648	20.37	32
33	Other(specify) Beauty	896	896	8,501	9.49	33
34	TOTAL (lines 1 - 33)	79,939	85,864	\$ 1,025,600 *	\$ 11.94	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	5	\$ 215	Ln 1, Col 3	35
36	Medical Director	24	4,800	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	84	4,198	Ln 10a, Col3	40
41	Occupational Therapy Consultant	9	452	Ln 10a, Col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	20	1,313	Ln 10a, Col 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	142	\$ 10,978		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Hancock County Nursing Home

0000091

Report Period Beginning: 07/01/04

Ending: 06/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership	
Name	Function	%	Amount		
Ada Bair	CEO	0	\$ 11,500		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 11,500		
B. Administrative - Other					
Description			Amount		
Pinkerton Services- compliance reporting			\$ 730		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 730		
C. Professional Services					
Vendor/Payee	Type		Amount		
Hartzell, Glidden, Tucker, Hartzell	Legal Fees		\$ 242		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 242		
D. Employee Benefits and Payroll Taxes					
Description			Amount		
Workers' Compensation Insurance			\$ 20,139		
Unemployment Compensation Insurance			564		
FICA Taxes			61,685		
Employee Health Insurance			268,691		
Employee Meals					
Illinois Municipal Retirement Fund (IMRF)*					
Other			77		
Life Insurance			2,082		
Retirement Contribution			10,041		
Dental Insurance			10,056		
TOTAL (agree to Schedule V, line 22, col.8)			\$ 373,335		
E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Description	Line #		Amount		
			\$		
TOTAL			\$		
F. Dues, Fees, Subscriptions and Promotions					
Description			Amount		
IDPH License Fee			\$		
Advertising: Employee Recruitment					
Health Care Worker Background Check (Indicate # of checks performed)			124		
Public Relations Advertising			3,914		
Administrative Subscriptions			309		
NH Association Dues			14,687		
Less: Public Relations Expense			(
Non-allowable advertising			(3,913)		
Yellow page advertising			(
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 15,121		
G. Schedule of Travel and Seminar**					
Description			Amount		
Out-of-State Travel			\$		
In-State Travel					
Seminar Expense			2,360		
Entertainment Expense			(
(agree to Sch. V, line 24, col. 8)					
TOTAL			\$ 2,360		

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number **Hancock County Nursing Home**

STATE OF ILLINOIS

0000091

Report Period Beginning:

07/01/04

Ending:

Page 23

06/30/05

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN-\$1,537, INHAA- \$100, LSN- \$1,537
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,248 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO NO No If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 31,209
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 99
c. What percent of all travel expense relates to transportation of nurses and patients? 99
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: BKD,LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not yet completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

FACILITY NAME: Hancock County Nursing Home
ID#: 0000091

BEGINNING: 7/1/2004
ENDING: 6/30/2005

VI. ADJUSTMENT DETAIL**RENTED FACILITY SPACE**

Non-care space rented to Memorial Hospital.

Occupancy costs allocated based on square footage.

Department Use	Square Feet Gross	Nursing Home %	Hospital (Non-Care) %	Nursing Home Sq. Ft.	Hospital (Non-Care) Sq. Ft.
Upper Level - Nursing Home	15,585	100.0%	0.00%	15,585	-
Lower Level - Shared Space:					
Allocated by time spent:					
Medical Records	1,418	5.00%	95.00%	71	1,347
Business Office	264	1.00%	99.00%	3	261
Data Processing	416	3.00%	97.00%	12	404
Pharmacy	912	0.00%	100.00%	-	912
Physical Therapy	160	0.00%	100.00%	-	160
Occupational Therapy	160	0.00%	100.00%	-	160
Nursing Admin Office	253	0.00%	100.00%	-	253
CFO	206	7.00%	93.00%	14	192
Purchasing	192	5.00%	95.00%	10	182
Accounting	216	5.50%	94.50%	12	204
Personnel	121	7.00%	93.00%	8	113
Administration	281	30.00%	70.00%	84	197
Risk Management	214	5.00%	95.00%	11	203
Beauty Shop	192	100.00%	0.00%	192	-
Subtotal	5,005	8.33%	91.67%	417	4,588
Common areas	7,700	8.33%	91.67%	641	7,059
Subtotal	12,705		-	1,058	11,647
Allocated by square feet:					
Plant operations	2,665	58.83%	41.17%	1,568	1,097
Housekeeping	160	58.83%	41.17%	94	66
Total lower level	15,530		-	2,720	12,810
Total facility space	31,115			18,305	12,810
Net rented space					
	12,810	41.17%			
Total facility space	31,115	100.00%			

Occupancy Costs	Total Costs	Allocation %	Non-Care Allocation	Sch V Line Ref
Utilities	\$77,776	41.17%	\$32,020	5
Maintenance	50,569	41.17%	20,819	6
Property Insurance	21,100	41.17%	8,687	26
Totals	\$149,445		\$61,526	